New Jersey Department of Health and Senior Services
AIDS Drug Distribution Program (ADDP)
PO Box 722
Trenton, NJ 08625-0722

# CERTIFICATION BY PHYSICIAN

*If you need assistance completing this form, call toll free 1-877-613-4533.*

## SECTION I - TO BE COMPLETED BY APPLICANT

*Please complete the requested information in Section I. Forward to your physician for completion of Section II. Ask your physician to return the completed form to you.*

| Name | Social Security Number |
|---|---|
| Address | Date of Birth |

## PERMISSION FOR RELEASE OF INFORMATION

*I hereby give permission to my physician to release the requested information to the New Jersey Department of Health and Senior Services for the purpose of determining my eligibility to participate in the AIDS Drug Distribution Program.*

| Signature of Applicant | Date |
|---|---|

## SECTION II - TO BE COMPLETED BY PHYSICIAN

*The individual named above has applied to the New Jersey Department of Health and Senior Services for participation in the AIDS Drug Distribution Program. Please provide the following information regarding the above applicant. Return this completed Certification form to the applicant to submit along with the completed Application.*

1. Is the applicant HIV+ (lab confirmed)? ☐ Yes ☐ No
2. Does the applicant meet CDC criteria for AIDS? ☐ Yes ☐ No
3. Date of the most recent T Helper (CD4+) lymphocyte count test (if test not done use "00/00"; if unknown use "99/99"): ____ ____ / ____ ____ (Month / Year)
   a. Absolute CD4+ lymphocyte count for the above test: _____ cells/mm3
   b. Percent CD4+ lymphocyte count for the above test: _____ %
4. Date of the most recent viral load test (if test not done use "00/00"' if unknown use "99/99"): ____ ____ / ____ ____ (Month / Year)
   a. Viral load: _____ Results
5. Date of the most recent reactive PPD test (if test not done use "00/00"; if unknown use "99/99"): ____ ____ / ____ ____ (Month / Year)
6. Current TB status:
   - ☐ Evidence of TB, Active, Receiving Treatment
   - ☐ Evidence of TB, Active, No Treatment
   - ☐ Evidence of TB, Active, Treatment Unknown
   - ☐ Evidence of TB, Inactive, Prophylaxis
   - ☐ Evidence of TB, Inactive, No Prophylaxis
   - ☐ No Evidence of TB
   - ☐ Unknown
7. Proposed treatment regimen (Check only one box):
   - ☐ Protease Inhibitor (PI) Based Combination Therapy
   - ☐ Nucleoside Analog Combination Therapy (not including a PI)
   - ☐ No Antiviral Therapy
8. Have Protease Inhibitors been previously prescribed to the applicant? ☐ Yes ☐ No
   a. If yes, name the Protease Inhibitor prescribed: _____

## CERTIFICATION

*I hereby certify that the above-named applicant has a medical necessity to obtain FDA-approved AIDS/HIV-related drugs.*

| Name of Physician (Print) | License Number and State |
|---|---|
| Street Address | Telephone Number |
| City, State, Zip Code | |
| Signature | Date |

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*Applicant: Forward this completed Certification to ADDP, along with your completed Application.*